STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	08/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 20, 21, 22, 23, and 24, 2012. Facility number: 000538 Provider number: 155620 AIM number: 100267290 Survey team: Heather Lay, RN-TC Janet Stanton, RN Melanie Strycker, RN Census bed type: SNF: 11 SNF/NF: 144 Residential: 80 Total: 235 Census payor type: Medicare: 22 Medicaid: 113 Other: 100 Total: 235 Sample: 24 Residential sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and request a **desk review** on or after September 23, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on September 4, 2012 by Bev Faulkner, RN			

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F0164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, record review, and interview, the facility failed to provide personal privacy during administration of eye drops to a cognitively impaired resident in the activity room. This deficient practice affected 1 of 10 residents observed during medication pass. [Resident #107]	F0164	F 164 Personal Privacy/Confidentiality of Records This provider ensures the resident has the right to personal privacy and confidentiality of his or her personal and clinical records. **What corrective action(s) will be accomplished for those residents found to have been affected by the**	09/21/2012

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	Findings include: 1. On 8/21/12 at 9:22 A.M., Licensed Practical Nurse [LPN #1] was observed administering eye drops, "Tears Natural Balance" to both eyes of Resident #107 in the B-wing activity room [an area located beside the nurse's station that was open without doors and visible from the hallway]. LPN #1 did not ask Resident #107 for permission to give the eye drops in the activity room. In addition, Resident #107 did not communicate with LPN #107. Resident #107 appeared alert; however, did not verbally respond to LPN #1. During eye drop administration, eight residents were observed in the activity room. On 8/21/12 at 1:20 P.M., Resident #107's record was reviewed. Diagnoses included, but were not limited to, dementia, dysphagia, anxiety, and depression. "Physician's Orders," dated 8/1/12 through 8/31/12, included, but were not limited to, "Tears Natural Balance Solution... Instill 2 drops into both eyes 3 times daily...."		**deficient practice?** Resident # 107: the resident receives eye drops in the privacy of his/her room, or private area. Resident exhibited no signs/symptoms of psychosocial affect from the alleged deficient practice. The Licensed Nurse received re-education regarding resident privacy and confidentiality. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Residents who receive eye drops have the potential to be affected by the alleged deficient practice. Resident eye drop administration is completed in the privacy of the resident's room or a private area. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Licensed nurses and Qualified Medication Aides were re-educated on privacy and confidentiality regarding the administration of medications on August 28, 2012, and ongoing. Education was provided by the Staff Development Coordinator and Director of Nursing Services. Nursing and department supervisors monitor resident care, including medication administration during daily rounds, especially in common areas, i.e. dining and activity rooms. Concerns are immediately	

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	On 8/21/12 at 3:00 P.M., in an interview, the Director of Nursing [DoN] indicated the facility did not have a policy and procedure on where to give medications; however, she indicated staff should not give eye drops in an activity area. 3.1-3(o) 3.1-3(p)(2)		corrected and reported to the Director of Nursing, or designee, and re-education and/or disciplinary action is provided, as needed. The Director of Nursing Services is responsible for compliance with medication administration. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Dignity and Privacy CQI tool will be completed for 5 residents daily x 4 weeks, monthly x 2 and quarterly x 3, to ensure resident privacy and confidentiality is upheld. Through the audits, if any non compliance is noted, corrective action will be completed immediately. The audits will be reviewed by the CQI committee and if a threshold of 95% compliance is not met an action plans will be developed to ensure continued compliance.	

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the	F0225	F 225 Investigate/Report	09/21/2012

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	facility failed to report an allegation of alleged verbal abuse immediately to the facility Administrator, Director of Nursing, or Nurse Supervisor, and to State Agencies. In addition the facility failed to suspend the alleged violator [LPN #9] and failed to do a thorough investigation. The deficient practice affected 1 of 1 resident reviewed for verbal abuse allegations in a sample of 24 residents reviewed. [Resident #132] Findings include: 1. On 8/20/12 at 10:45 A.M., tour was initiated with Licensed Practical Nurse [LPN] #8. At that time, Resident #132 was identified as being interviewable and independent with his activities of daily living. On 8/21/12 at 9:30 A.M., Resident #132 requested to speak with an ISDH surveyor at 12:30 P.M., after he returned from physical therapy. On 8/21/12 at 12:30 P.M., in an interview, Resident #132 indicated he had a concern regarding an incident that happened in early August, 2012, on a Saturday with LPN #9. He indicated that during breakfast, LPN #9 intimidated him by yelling in his face and pointing at him at a close distance. Resident #132		Allegations/Individuals It is the practice of this provider to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including the State survey and certification agency). The facility ensures it has evidence that all alleged violations are thoroughly investigated, and prevents further potential abuse while the investigation is in progress. The results of all investigations is reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action is taken. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 132 – the resident allegation was investigated during the annual survey process and reported to the Indiana State Department of Health. The licensed nurse was suspended pending investigation. The employee received re-education from the Director of Nursing Services	

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	indicated he filled out a facility grievance form the same day; however, he was not happy with their [the facility] response. Resident #132 denied fearing for his safety from LPN #9 or any other staff member. He indicated the facility had taken care of a lot of his concerns just not the one with LPN #9. On 8/21/12 at 3:15 P.M., a verbal abuse investigation regarding Resident #132 was requested from the Executive Director and the Director of Nursing [DoN]. A "Resident/Family Concerns/Grievance Form" and additional documents regarding Resident #132 was received from the Director of Nursing [DoN] on 8/22/12 at 9:00 A.M. At that time, in an interview, the DoN indicated the facility did not report the incident to ISDH or follow the facility abuse prohibition policies and procedures for the reported grievance. The grievance form included, but was not limited to, "Resident Name: [Resident #132]... Date of Concern: 8/4/12... Time of Concern: 8 to A.M.... Date Concerned Received: 8/5/12 [no time]... Concern Received from: [marked] Resident... Executive Director Signature and Date:		regarding resident rights and customer service. Social Service provided psychosocial support to resident # 132 and the resident has voiced no further concerns. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. During the course of the investigation, other residents were interviewed regarding interactions with Licensed Nurse #9 and no concerns were expressed. Resident allegations/concerns regarding abuse/neglect/misappropriation of funds/ISDH reportables are reported to the Administrator, and/or designee and an investigation is initiated immediately. Resident's attending physician and responsible party are notified of any allegation of abuse/neglect/ISDH reportable guidelines. Employees named in an allegation are immediately suspended, pending investigation. Corrective action will be taken, as indicated. The allegation is initially reported to ISDH as soon as possible and a follow-up report is made within 5 days. Social Service provides psychosocial support to the	

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	[signed on 8/13/12]... Nature of Concern: [LPN #9] yelling at me in the dining room standing 1 ft [foot] away trying to intimidate me... this incident is not the first..." The other documents included, but were not limited to, written narratives from LPN #9 [alleged violator] and LPN #10 [weekend supervisor]. A written narrative dated 8/4/12, no time, from LPN #9, included, but was not limited to, "[Resident #132] was in the Crystal Dining Room yelling at staff, staff address [sic] his concern, he stated staff should have started with him passing coffee... continued to yell and used profanity at staff stating he pays everyone [sic] salary... staff asked [Resident #132] if he would like breakfast in his room [sic] he stated no... [other] residents in dining room wanted staff to escort him [Resident #132] out..." A written narrative, no date or time, from LPN #10, included, but was not limited to, "On sat [sic] 8/4/12 [no time] I was told by staff that [Resident #132] wanted to see me and talk to me about dietary staff... he told me that he did not receive what he had ordered today, but was tired of not getting served first... I told him I would look into dietary situation... He		resident, as needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff re-education was provided by the Staff Development Coordinator and Social Service Director related to the facility abuse policy and procedure on August 28, 2012, and ongoing. The facility conducts Criminal Background checks upon hire and only those prospective employees without criminal history background, per company policy, are hired. Employees are educated by Staff Development Coordinator regarding the abuse/Neglect/misappropriation/ISDH reportable guidelines policy and procedure, including reporting any allegation of abuse to the administrator and/or designee, upon hire, and no less than annually, and as needed. Employees were re-educated By Staff Development Coordinator on the facility Concern and Grievance Policy and Procedure on August 28, 2012, and ongoing. Resident/Family concern forms are located at nursing units and the receptionist desk to ensure residents and families have an opportunity to voice their concerns, including any allegation of abuse and/or neglect. The Administrator is notified of allegations of abuse/neglect immediately.	

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	[Resident #132] then yelled my name [as LPN #10 was leaving his room] and stated I want to tell you something else... He [Resident #132] stated that a nurse [LPN #9] had yelled at him and that he wanted me to check into it... He stated that he was in the dinning [sic] room and that he was telling staff that he wanted to be served first... He stated the nurses [sic] came over started yelling at him in a threatening way... I asked him if he was scared and he said no, so I asked has this ever happened to you before and he said no, so then I asked if he felt threatened and he stated no, but she [LPN #9] had no right to correct me... I asked him if he would like to fill out an orange form [facility grievance form] and he said yes... I told him I would talk to the staff and follow up with him... I did go talk to the nurse [LPN #9] who stated that he was yelling and swearing at the staff and hitting the table and disregarding residents... She [LPN #9] stated that she did tell him that he needed to calm down and stop yelling at the staff and res [sic]... She stated he was very rude but did stop yelling and calmed down and she thought everything was fine..." On 8/23/12 at 10:05 A.M., Resident #132's record was reviewed. Diagnoses included, but were not limited to, anxiety, depressive disorder, and cerebrovascular		The Administrator is responsible to monitor compliance with the Abuse Policy and Procedure Program as well as the overall investigative process regarding abuse allegations. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Abuse Prohibition and Investigation CQI tool will be utilized with 10 staff members weekly x 4, 10 staff members monthly x 2 and 10 staff members quarterly x 3. The audits will be reviewed by the CQI committee and if a threshold of 100% compliance is not met, action plans will be to ensure continued compliance.	

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	disease. A "Resident Progress Notes," dated 8/4/12 at 8:30 A.M., included, but was not limited to, "Staff Certified Nursing Assistant [CNA] #11 informed writer [LPN #9] that resident [Resident #132] was yelling and cursing at her because she did not give him coffee first. Writer asked resident to calm down and stop yelling because there are other residents in the dining room. Resident continued to yell, curse, and pointing his finger... Writer informed resident that this behavior is not tolerated..." A "Resident Progress Notes," dated 8/4/12 at 1:44 P.M., included, but was not limited to, "This writer [LPN #12] made aware by nursing staff that res [sic] yelling and using profanity in the dining room this am [sic] during breakfast... Requested to speak with management... Management [weekend supervisor LPN #10] made aware of res [sic] request..." On 8/23/12 at 10:45 A.M., in an interview, the Executive Director indicated LPN #9 was suspended from work on 8/23/12 and the facility was doing a thorough investigation of the incident regarding Resident #132. In addition, the Executive Director indicated the interim Executive Director was not			

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	made aware of the allegation of verbal abuse. The facility did not thoroughly investigate the incident with Resident #132 as an allegation of verbal abuse and did not suspend the alleged violator [LPN #9] at the time Resident #132 notified staff of the incident. The abuse policies and procedures included, but were not limited to, "Verbal Abuse: defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families... Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never by able to see his/her family again; or scolding and/or speaking to them in harsh voice tone... All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative within 24 hours of the report... Failure to report will result in disciplinary action, up to and including immediate termination... Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed...The Executive Director will report all unusual			

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	occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health..." 3.1-28(c)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to identify a resident grievance as an allegation of abuse and follow their policies and procedures related to reporting immediately to the Executive Director, failed to do a thorough investigation, and failed to suspend the staff member from work during the investigation. [Resident #132] Findings include: 1. On 8/20/12 at 10:45 A.M., tour was initiated with Licensed Practical Nurse [LPN] #8. At that time, Resident #132 was identified as being interviewable and independent with his activities of daily living. On 8/21/12 at 9:30 A.M., Resident #132 requested to speak with an ISDH surveyor at 12:30 P.M., after he returned from physical therapy. On 8/21/12 at 12:30 P.M., in an interview, Resident #132 indicated he had a concern regarding an incident that	F0226	F 226 Develop/Implement Abuse/Neglect, Etc. Policies It is the practice of this provider to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Resident # 132 – the resident allegation was investigated during the annual survey process and reported to the Indiana State Department of Health. The licensed nurse was suspended pending investigation. The employee received re-education from the Director of Nursing Services regarding resident rights and customer service. Social Service provided psychosocial support to resident # 132 and the resident has voiced no further concerns. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	09/21/2012

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	happened in early August, 2012, on a Saturday with LPN #9. He indicated that during breakfast, LPN #9 intimidated him by yelling in his face and pointing at him at a close distance. Resident #132 indicated he filled out a facility grievance form the same day; however, he was not happy with their [the facility] response. Resident #132 denied fearing for his safety from LPN #9 or any other staff member. He indicated the facility had taken care of a lot of his concerns just not the one with LPN #9. On 8/21/12 at 3:15 P.M., a verbal abuse investigation regarding Resident #132 was requested from the Executive Director and the Director of Nursing [DoN]. A "Resident/Family Concerns/Grievance Form" and additional documents regarding Resident #132 were received from the Director of Nursing [DoN] on 8/22/12 at 9:00 A.M. At that time, in an interview, the DoN indicated the facility did not report the incident to ISDH or follow the facility abuse prohibition policies and procedures for the reported grievance. The grievance form included, but was not limited to, "Resident Name: [Resident		All residents have the potential to be affected by the alleged deficient proactice. During the course of the investigation, other residents were interviewed regarding interactions with Licensed Nurse #9 and no concerns were expressed. Resident allegations/concerns regarding abuse/neglect/misappropriation of funds/ISDH reportables are reported to the Administrator, and/or designee and an investigation is initiated immediately. Resident's attending physician and responsible party are notified of any allegation of abuse/neglect/ISDH reportable guidelines. Employees named in an allegation are immediately suspended, pending investigation. Corrective action will be taken, as indicated. The allegation is initially reported to ISDH as soon as possible and a follow-up report is made within 5 days. Social Service provides psychosocial support to the resident, as needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff re-education was provided by the Staff Development Coordinator and Social Service Director related to the facility abuse policy and procedure on August 28, 2012, and ongoing. The facility	

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	#132]... Date of Concern: 8/4/12... Time of Concern: 8 to A.M.... Date Concerned Received: 8/5/12 [no time]... Concern Received from: [marked] Resident... Executive Director Signature and Date: [signed on 8/13/12]... Nature of Concern: [LPN #9] yelling at me in the dining room standing 1 ft [foot] away trying to intimidate me... this incident is not the first..." The other documents included, but were not limited to, written narratives from LPN #9 [alleged violator] and LPN #10 [weekend supervisor]. A written narrative, dated 8/4/12, no time, from LPN #9, included, but was not limited to, "[Resident #132] was in the Crystal Dining Room yelling at staff, staff address [sic] his concern, he stated staff should have started with him passing coffee... continued to yell and used profanity at staff stating he pays everyone [sic] salary... staff asked [Resident #132] if he would like breakfast in his room [sic] he stated no... [other] residents in dining room wanted staff to escort him [Resident #132] out..." A written narrative, no date or time, from LPN #10, included, but was not limited to, "On sat [sic] 8/4/12 [no time] I was told by staff that [Resident #132] wanted		conducts Criminal Background checks upon hire and only those prospective employees without criminal history background, per company policy, are hired. Employees are educated by Staff Development Coordinator regarding the abuse/Neglect/misappropriation/ISDH reportable guidelines policy and procedure, including reporting any allegation of abuse to the administrator and/or designee, upon hire, and no less than annually, and as needed. Employees were re-educated By Staff Development Coordinator on the facility Concern and Grievance Policy and Procedure on August 28, 2012, and ongoing. Resident/Family concern forms are located at nursing units and the receptionist desk to ensure residents and families have an opportunity to voice their concerns, including any allegation of abuse and/or neglect. The Administrator is notified of allegations of abuse/neglect immediately. The Administrator is responsible to monitor compliance with the Abuse Policy and Procedure Program as well as the investigative process regarding abuse allegations. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Abuse Prohibition and	

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	to see me and talk to me about dietary staff... he told me that he did not receive what he had ordered today, but was tired of not getting served first... I told him I would look into dietary situation... He [Resident #132] then yelled my name [as LPN #10 was leaving his room] and stated I want to tell you something else... He [Resident #132] stated that a nurse [LPN #9] had yelled at him and that he wanted me to check into it... He stated that he was in the dinning [sic] room and that he was telling staff that he wanted to be served first... He stated the nurses [sic] came over started yelling at him in a threatening way... I asked him if he was scared and he said no, so I asked has this ever happened to you before and he said no, so then I asked if he felt threatened and he stated no, but she [LPN #9] had no right to correct me... I asked him if he would like to fill out an orange form [facility grievance form] and he said yes... I told him I would talk to the staff and follow up with him... I did go talk to the nurse [LPN #9] who stated that he was yelling and swearing at the staff and hitting the table and disregarding residents... She [LPN #9] stated that she did tell him that he needed to calm down and stop yelling at the staff and res [sic]... She stated he was very rude but did stop yelling and calmed down and she thought everything was fine..."		Investigation CQI tool will be utilized with 10 staff members weekly x 4, 10 staff members monthly x 2 and 10 staff members quarterly x 3. The audits will be reviewed by the CQI committee and if a threshold of 100% compliance is not met, action plans will be to ensure continued compliance.	

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On 8/23/12 at 10:05 A.M., Resident #132's record was reviewed. Diagnoses included, but were not limited to, anxiety, depressive disorder, and cerebrovascular disease.

"Resident Progress Notes," dated 8/4/12 at 8:30 A.M., included, but was not limited to, "Staff Certified Nursing Assistant [CNA] #11 informed writer [LPN #9] that resident [Resident #132] was yelling and cursing at her because she did not give him coffee first. Writer asked resident to calm down and stop yelling because there are other residents in the dining room. Resident continued to yell, curse, and pointing his finger... Writer informed resident that this behavior is not tolerated..."

A "Resident Progress Notes," dated 8/4/12 at 1:44 P.M., included, but was not limited to, "This writer [LPN #12] made aware by nursing staff that res [sic] yelling and using profanity in the dining room this am [sic] during breakfast... Requested to speak with management... Management [weekend supervisor LPN #10] made aware of res [sic] request..."

On 8/23/12 at 10:45 A.M., in an interview, the Executive Director indicated LPN #9 was suspended from

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	work on 8/23/12 and the facility was doing a thorough investigation of the incident regarding Resident #132. In addition, the Executive Director indicated the interim Executive Director was not made aware of the allegation of verbal abuse. The facility did not thoroughly investigate the incident with Resident #132 as an allegation of verbal abuse and did not suspend the alleged violator [LPN #9] at the time Resident #132 notified staff of the incident. The abuse policies and procedures included, but were not limited to, "Verbal Abuse: defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families... Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never by able to see his/her family again; or scolding and/or speaking to them in harsh voice tone... All abuse allegations/abuse must be reported to the Executive Director immediately, and to the resident's representative within 24 hours of the report... Failure to report will result in disciplinary action, up to and including immediate termination... Any staff			

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	member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed...The Executive Director will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health..." 3.1-28(a)			

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F0323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure that potentially hazardous chemicals were not accessible to residents. This deficient practice had the potential to affect 9 of 24 residents who resided on a Memory Care unit (a locked/secured Alzheimer's/dementia unit) who ambulated independently in a wheelchair and 4 of 34 residents on B Hall who were confused and up ad lib (independently). Findings include: On 8/20/12 at 10:35 A.M., a tour of Cottage 2 (the locked/secured Alzheimer's/dementia unit) was initiated with LPN #3. LPN #3 indicated there were nine (9) residents on this unit who ambulated independently in wheelchairs. On 8/20/12 at 10:35 A.M., a tour of B Hall was initiated with LPN #8. LPN #8 indicated there were four (4) residents on this hall who were confused and up ad lib (independently).	F0323	F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Cottage 2: Hazardous items located on the linen cart on Cottage 2 were removed and secured immediately. B Wing: Hazardous items found in the unlocked room on B Wing were immediately removed and secured, and a keypad lock was installed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Residents who are confused and up independently have the potential to be affected by the alleged deficient practice.	09/21/2012

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	On 8/23/12 at 9:20 A.M., the tour of the environment was initiated with the Assistant Executive Director, the Maintenance Supervisor, and the Laundry/Housekeeping Supervisor in attendance. On 8/23/12 at 9:55 A.M., an unlocked room on B Hall was found to contain three 8.5 ounce bottles of "McKesson Wash for Hair and Body." The labels of each bottle indicated this product was for "External use only. Discontinue if irritation occurs. Avoid contact with eyes. In case of eye contact flush with water and contact a physician." In an interview at this time, the Maintenance Supervisor indicated he would likely install a coded lock on the door to this room. Also in this same unlocked room was a 4 ounce bottle of "McKesson Moisturizing Skin Care Lotion." The label indicated this product was for "External use only. Discontinue if irritation occurs. Avoid contact with eyes. In case of eye contact flush with water and contact a physician." Also in this same unlocked room were three 2.47 ounce tubes of "Smith & Nephew Secura Protective Ointment" that contained a label indicating this product		The Unit supervisors monitor resident common areas to ensure hazardous products are secured and do not come into direct contact with residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Staff was re-educated by the Staff Development Coordinator regarding hazardous items on August 28, 2012, and ongoing, The dementia unit and nursing unit environments are monitored daily by supervisors and department heads. Should noncompliance be noted, corrective action will be taken immediately. The Director of Nursing Services is responsible for compliance with environmental hazards. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Care Rep Daily rounds Checklist will be utilized on all units daily x 30 days, monthly x 2 and quarterly x 3. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met action plans will be developed, to ensure continued compliance.	

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	was for "External use only. Avoid contact with the eyes. Keep out of reach of children. If swallowed get medical help or contact a Poison Control Center immediately." On 8/23/12 at 10:45 A.M., a linen cart was observed outside of resident room #525 on Cottage 2. This cart contained clean linens and a 300 ml bottle of "Array perineal wash" that contained a label indicating, "Keep out of reach of children. For external use only." Also in the linen cart was an 11 ounce can of "McKesson Medi-Pak shaving cream" with a label indicating, "Contents under pressure. Keep out of reach of children." In an interview at this time, the Memory Care Facilitator indicated he would have the nurse secure the items. 3.1-45(a)(1)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to ensure a blood pressure was checked prior to administering a blood pressure medication, in order to follow a physician's orders to "Hold" the medication for specified blood pressure parameters, for 1 of 2 residents who had such orders; in a sample of 24 residents reviewed. [Resident #81] Findings include: In an interview during the initial	F0329	**F 329 Drug Regimen is Free From Unnecessary Drugs** It is the practice of this provider to ensure that each resident's drug regimen is free from necessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy): or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	09/21/2012

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	orientation tour on 8/20/12 at 10:35 A.M., L.P.N. #3 indicated Resident #81 had a history of falls. The resident was currently using a wheelchair for mobility most of the time, but was able to ambulate. The clinical record for Resident #81 was reviewed on 8/21/12 at 10:30 A.M. Diagnoses included, but were not limited to, coronary artery disease with stents, hyperlipidemia [high cholesterol], dementia, and hypertension [high blood pressure]. On 7/9/12, the physician gave an order for Metoprolol [a Beta Blocker medication used to treat hypertension, angina, congestive heart failure] 25 mg. [milligrams]--1/2 tablet daily, "Hold if systolic blood pressure is less than 100, or heart rate less than 60. Notify M.D. if systolic blood pressure is greater than 150." The medication was scheduled to be given at 9:00 A.M. daily. On 8/22/12 at 9:30 A.M., the August, 2012 M.A.R. [Medication Administration Record] was reviewed. The order for the Metoprolol was listed, with a hand-written notation for the "Hold" parameters. There were no blood pressure or heart rate vital signs documented on the M.A.R.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 81's blood pressure is monitored per MD order and the MD is notified if the systolic blood pressure is less than 100, or the heart rate is less than 60. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with physician orders for blood pressure parameters have the potential to be affected. All residents with blood pressure parameters have been identified and reviewed by attending physician, or designee. Resident plans of care and medication	

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	In an interview at that time, R.N. #6 indicated the blood pressures and heart rates were not done because they was not listed on the M.A.R. She indicated she did not believe the blood pressures would be marked any place else. During the daily conference on 8/22/12 at 4:15 P.M., the Director of Nursing was given the opportunity to submit the July, 2012 M.A.R. and any other documentation demonstrating blood pressures and heart rates were checked in order to determine if the medication should be held. On 8/23/12 at 4:00 P.M., the Director of Nursing provided 3 pages of a M.A.R. for July, 2012. The order for the Metoprolol was not listed on any of the three pages provided. The Director of Nursing also provided a "Vitals Report" printout from the electronic records, listing blood pressures taken in July and August, 2012. Blood pressure levels were documented for 7/11, 12, 14, 15, 18, 19, 23, 24, and 27. Six of the blood pressures were checked in the afternoon and evenings, the earliest at 1:26 P.M. The other 3 blood pressures were checked in the morning, with one at 5:11 A.M., one at 6:33 A.M., and the other at 11:50 A.M.		administration records were updated, as needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Licensed nurses were re-educated by the Staff Development Coordinator and Director of Nursing Services regarding the monitoring of blood pressure parameters and following physician orders on August 28, 2012, and will continue to be educated ongoing. Blood pressure parameters for identified residents have been added to the resident's Medication Administration Record. Nurses will document blood pressure results on the resident's Medication Administration Record, and administer medications per physician order. The Unit Manager or designee will review the Medication Administration every shift to ensure that blood pressures were taken per physician orders. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	Systolic blood pressures for the 9 measurements documented, ranged from 109 to 126. Heart rates were not included in the print-out. 3.1-35(g)(2)		**assurance program will be put into place?** Medication Administration Records will be audited by nurse managers for completion and documentation of blood pressure medication, daily x 30 days, weekly x 4, monthly x 1, and quarterly x 3. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met action plans will be developed to ensure ongoing compliance.	

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to ensure that 2-step testing	F0441	**F 441 Infection Control, Prevent Spread** This provider	09/21/2012

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	for tuberculosis (TB) was completed within 3 months prior to admission or upon admission to the facility. This deficient practice affected 7 residents in a sample of 24 residents reviewed. (Residents #87, #119, #139, #140, #153, #157, #158) Findings include: 1. The clinical record of Resident #139 was reviewed on 8/21/12, at 10:38 A.M. Resident #139 was admitted to the facility on 4/27/12. Diagnoses included, but were not limited to, pressure ulcer- stage IV, anxiety, depressive disorder, multiple sclerosis, peripheral vascular disease, esophageal reflux, anemia of chronic disease, contractures, weakness, osteoporosis, urostomy, colostomy, and paraplegia. A first step TB skin test was administered on 7/26/12 and was read on 7/30/12. There was no documentation that a first step TB skin test was administered prior to or on 4/27/12. 2. The clinical record of Resident #140 was reviewed on 8/22/12, at 3:25 P.M. Resident #140 was admitted to the facility on 7/31/12. Diagnoses included, but were not limited to, above knee amputation, chronic pain, acute lung edema, diabetes mellitus, history of gangrene, ischemic heart disease, malnutrition vitamin D		establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents # 139, # 153, #119, #87 – The resident's 1 st and 2 nd step tuberculin testing has been initiated and will be completed timely. Residents # 140, # 157 and # 158 no longer reside at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Residents have a 2-step testing for tuberculosis (TB) and may be completed within 3 months prior to admission and upon admission to the facility. The facility conducted an audit and any residents needing tuberculin testing were identified and PPDs have been placed and/or are in the process of continuing the series. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not**	

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	deficiency, hyperlipidemia (elevated cholesterol), depressive disorder, hemiplegia (paralysis of one side of the body), rheumatic aortic stenosis (narrowing of aortic valve), hypertension, congestive heart failure, and cerebrovascular disease. A first step TB skin test was administered on 8/1/12, the day after admission, and was read on 8/3/12. There was no documentation that a first step TB skin test was administered prior to or on 7/31/12. 3. The clinical record of Resident #153 was reviewed on 8/21/12, at 9:25 A.M. Resident #153 was admitted to the facility on 7/12/12. Diagnoses included, but were not limited to, aphasia (difficulty with or inability to speak), stroke, atrial fibrillation, history of hypertension, congestive heart failure, bronchitis, asthma, dyspnea (shortness of breath), and dysphagia (difficulty swallowing). A first step TB skin test was administered on 7/16/12, 4 days after admission, and was read on 7/19/12. An order on the medication administration record (MAR) read, "Give 2nd step PPD [tuberculosis skin test] 7/30/12 and read 8/2/12." There was no indication a 2nd step TB skin test was administered on 7/30/12. An additional "first step" TB skin test was administered on 8/12/12. There was no indication that this test was read.		**recur?** Licensed nurses were re-educated on the scheduling and administration of resident PPDs on August 28, 2012 by the Staff Development Coordinator. The facility conducted a TB Testing Certification Class on August 31, 2012, and September 14, 2012, and will continue to have opportunities for Licensed Nurses to become and/or remain PPD certified. Residents are assessed upon admission for PPDs. The 1 st Step PPD is given on date of admission, if not given prior to admission and the charge nurse schedules the necessary steps to complete the series. Annual PPDs have been scheduled, as needed. Nurse managers review the resident's hospital information on the day of admission to determine the date of the resident's 1 st Step PPD and schedules the series, as necessary. Nurse managers review the resident's medical record the day after the admission to the facility to ensure the 1 st Step PPD has been administered and scheduled to be read and the 2 nd Step series is scheduled. The Director of Nursing Services or designee will also run a report from the Electronic Medical Record monthly that will indicated any resident who does not have a current PPD documented. The Director of Nursing Services is responsible to ensure compliance with resident PPD	

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	4. On 8/22/12 at 11:15 A.M., Resident #119's record was reviewed. Diagnoses included, but were not limited to, dementia, pain, dysphagia, and constipation. Resident #119 was admitted to the facility on 7/20/12. There was no documentation of an admission tuberculin skin test for Resident #119. An "Event Report," dated 8/12/2012, included but was not limited to, "Mantoux/PPD Documentation... Date administered: 8/12/12... Type of Mantoux/PPD: 1st step... Date read: 8/15/12: Negative 0 millimeters [induration]..."		administration. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Resident Mantoux CQI tool will be utilized daily x 30 days on new admissions, weekly x 4, monthly x 2, and quarterly. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met, action plans will be developed to ensure ongoing compliance.	

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	There was no documentation of a 2nd step tuberculin skin test. 5. On 8/23/12 at 1:15 P.M., Resident #158's closed record was reviewed. Diagnoses included, but were not limited to, status post coronary artery bypass graft, myocardial infarction, and mild hypoxic ischemic encephalopathy. Resident #158 was admitted to the facility on 6/11/12 and discharged to a local hospital on 6/15/12. There was no documentation of an admission tuberculin skin test in Resident #158's closed clinical record. 6. On 8/24/12 at 1:00 P.M., Resident #157's closed record was reviewed. Diagnoses included, but were not limited to, glioblastoma multiforme. There was no documentation of an admission tuberculin skin test in Resident #157's closed clinical record. 7. The clinical record for Resident #87 was reviewed on 8/22/12 at 3:10 P.M. The electronic medical record indicated the resident was admitted to the secured/locked Alzheimer's unit on 5/10/12 with diagnoses of hypertension, cerebral vascular disease, and chronic obstructive pulmonary disease. He was			

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	transferred to the Moving Forward rehabilitation unit on 5/23, then to a general population unit on 6/29/12. On 7/10/12, he returned to the Cottage/Memory Care secured/locked unit. An admission first and second step P.P.D. [purified protein derivative] tuberculin skin test was not found in the paper or electronic medical record. In an interview on 8/24/12 at 2:00 P.M., the Director of Nursing indicated the resident had also lived in the Assisted Living/Residential area, and had moved in and out of that part of the facility. She indicated she was unable to find any documentation of a P.P.D. skin test or other tuberculosis screen. 9. The facility policy and procedure for "Resident Screening-Tuberculosis" dated 12/2011, included, but was not limited to, "Policy: All residents, prior to or upon admission, will be screened for TB [tuberculosis] in accordance with state and federal regulations..." On 8/24/12 at 5:00 P.M., in an interview, the DoN indicated she was unable to provide further documentation of tuberculin skin testing for Residents #139, 140, 153, 157, 158, 119, and 87.			

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	3.1-18(e)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure complete and accurate documentation of B.M.s [bowel movements] were maintained in the computerized electronic health records for 3 of 24 residents reviewed. [Residents #68, #81, and #89] Findings include: 1. In an interview during the initial orientation tour on 8/20/12 at 10:55 A.M., L.P.N. #3 indicated Resident #68 would frequently yell out and resist care. The clinical record for Resident #68 was reviewed on 8/22/12 at 3:30 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type with delusions, depressive disorder,	F0514	**F 514 Resident Records – Complete/Accurate/Accessible** This provider maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record contains sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	09/21/2012

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	osteoarthritis, and constipation. The computerized electronic health record for documentation of B.M.s indicated the following: 5/15/12 to 5/20/12: A B.M. was recorded on 5/15, with the next one recorded on 5/20/12. All other entries between the two dates were marked "none." 6/6/12 to 6/10/12: A B.M. was recorded on 6/6, with the next one recorded on 6/10/12. All other entries between the two dates were marked "none." 6/21/12 to 6/26/12: A B.M. was recorded on 6/21, with the next one recorded on 6/26/12. All other entries between the two dates were marked "none." 6/26/12 to 6/30/12: A B.M. was recorded on 6/26, with the next one recorded on 6/30/12. All other entries between the two dates were marked "none." The electronic health record for "Events" and " Progress Notes" had no documentation that the resident experienced constipation, abdominal pain, or abdominal distention during these periods. 2. In an interview during the initial		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents # 68, #81, #89 are monitored daily for bowel movements. The residents are given laxatives, per physician order, and bowel assessments are completed, as needed. There have been no negative outcomes related to resident bowel status. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Resident bowel movements are documented in the electronic medical record by the Certified Nursing Assistant and/or Licensed nurse, each shift. The Licensed nurse runs a bowel report, from the electronic	

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	orientation tour on 8/20/12 at 10:35 A.M., L.P.N. #3 indicated Resident #81 had experienced a decline, and now used a wheelchair for mobility due to being unsteady during ambulation. The clinical record for Resident #81 was reviewed on 8/21/12 at 10:30 A.M. Diagnoses included, but were not limited to, senile dementia with delusions, hypertension, and osteoporosis. The resident had physician orders for Miralax routinely, and Milk of Magnesia as needed. The computerized electronic health record for documentation of B.M.s indicated the following: 3/31/12 to 4/6/12: A B.M. was recorded on 3/31, with next one recorded on 4/6/12. All other entries between the two dates were marked "none." 4/8/12 to 4/11/12: A B.M. was recorded on 4/8/12, with the next one recorded on 4/11/12. All other entries between the two dates were marked "none." 5/19/12 to 5/25/12: A B.M. was recorded on 5/19, with the next one recorded on 5/25/12. All other entries between the two dates were marked "none."		medical record, for their specific unit at the beginning of their shift to trend the resident's bowel movements over the previous 7 days. The nurse utilizes this report to determine if bowel management protocol will be initiated. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Licensed nurses and Certified Nursing Assistants were re-educated by the Staff Development Coordinator and Director of Nursing Services regarding documentation of bowel movements in the electronic medical record on August 28, 2012, and education will continue ongoing. Licensed nurses were reeducated by the Staff Development Coordinator and Director of Nursing Services regarding the facility bowel management protocol on Aug 28, 2012, and ongoing. The nurse managers run a bowel report per unit each morning prior to clinical rounds. Any resident found to not have a documented bowel movement in the previous 3 days will have the bowel	

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	The electronic health record for "Events" and " Progress Notes" had no documentation that the resident experienced constipation, abdominal pain, or abdominal distention during these periods. 3. In an interview during the initial orientation tour on 8/20/12 at 10:35 A.M., L.P.N. #3 indicated Resident #89 used a wheelchair for mobility, with a self-release seat belt which the resident was able to release by himself. The clinical record for Resident #89 was reviewed on 8/21/12 at 1:40 P.M. Diagnoses included, but were not limited to, dementia, Parkinson's disease, muscle spasms, osteoarthritis, and constipation. The computerized electronic health record for documentation of B.M.s indicated the following: 4/19/12 to 4/26/12: A B.M. was recorded on 4/19, with next one recorded on 4/26/12. All other entries between the two dates were marked "none." Progress notes from 4/19/12 to 4/26 indicated the resident had active bowel sounds in all four quadrants and had no abdominal distention. A P.R.N. [as needed] dose of Milk of Magnesia was given on 4/26/12.		protocol initiated. The unit manager, or designee, monitors bowel protocol follow-up **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Bowel Elimination CQI l will be utilized daily x 30, weekly x 4, monthly x 1, and quarterly to monitor compliance with bowel elimination. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met, action plans will be developed, to ensure ongoing compliance.	

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	6/14/12 to 6/20/12: A B.M. was recorded on 6/14, with the next one recorded on 6/20/12. All other entries between the two dates were marked "none." The electronic health record for "Events" and " Progress Notes" had no documentation that the resident experienced constipation, abdominal pain, or abdominal distention during this period. 7/1/12 to 7/6/12: A B.M. was recorded on 7/1, with the next one recorded on 7/6/12. All other entries between the two dates were marked "none." The electronic health record for "Events" and " Progress Notes" had no documentation that the resident experienced constipation, abdominal pain, or abdominal distention during this period. 7/15/12 to 7/22/12: A B.M. was recorded on 7/15, with the next one recorded on 7/22/12. All other entries between the two dates were marked "none." The electronic health record for "Events" and " Progress Notes" had no documentation that the resident experienced constipation, abdominal pain, or abdominal distention during this period. In an interview during the daily conference on 8/22/12 at 4:15 P.M., the Director of Nursing indicated a report related to B.M.s was generated daily, and			

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	reviewed during the daily rounds. If a resident had not had a B.M. in 3 days, the physician would be notified. She was given the opportunity to submit any documentation related to recording of bowel movements for Residents #68, #81, and #89. In an interview on 8/23/12 at 4:00 P.M., the Director of Nursing indicated she was not able to locate any ADL sheets with documentation of bowel movements. She suspected the information about B.M.s just didn't get documented due to occasional computer issues. 3.1-50(a)(1) 3.1-50(a)(2)			

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F9999	STATE FINDINGS 3.1-14 PERSONNEL (t)(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of the facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. This State Rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure that 4 of 5 new employees received tuberculosis testing by skin test or screen at or prior to hire; and 3 of 10 established employees received a timely annual skin test or screen. [Employees #4, #13, #14, #15, #16, #17, and #18] Findings include:	F9999	**F9999 Personnel** This provider ensures that at the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and non-paid personnel of the facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Employees # 4, # 13, # 14, # 15, # 16, # 17, and # 18 - 1 st and/or 2 nd Step PPDs and annual PPDs are up to date. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	09/21/2012

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ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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	Following the entrance conference on 8/20/12, the Executive Director provided a completed "Employee Records" forms [State Form 5440], listing all employees currently working in the facility. Five new hire employees, and 10 established employees, were randomly selected for file review. The personnel files for 4 new hires and 3 established employees had no documentation of first and/or second step, or timely annual P.P.D. [Purified Protein Derivative] skin tests, or other screens as follows: A. R.N. #14, with date of hire 8/1/12: A first step P.P.D. skin test was given on 7/30/12 and read on 8/2/12. A second step test was not found. There was no documentation that the employee had a negative P.P.D. in the preceding 12 months. B. C.N.A. #15, with a date of hire 8/15/12: A first and second step test was not found. C. C.N.A. #16, with a date of hire 7/11/12: There was a copy of documentation of a positive P.P.D. done on 8/8/11, with a chest-ray done on 8/11/11, at some other location. Documentation of a tuberculosis screen		All employees have the potential to be affected by the alleged deficient practice. Employees have a 2-step testing for tuberculosis (TB) upon hire and annual, if applicable. The facility conducted an audit and any employees needing tuberculin testing were identified and PPDs have been placed and/or are in the process of continuing the series. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The facility conducted a TB Testing Certification Class on August 31, 2012, and September 14, 2012, and will continue to have opportunities for Licensed Nurses to become or remain PPD certified.	

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	questionnaire completed at, or prior to, being hired at Zionsville Meadows was not found. D. R.N. #13, with a date of hire 4/11/12: The employee was identified on the "Employee Records" form as being a positive reactor to a P.P.D. test, date unknown. A chest x-ray was documented as done on 4/23/12, and was negative for active disease. E. Housekeeper #17, with a date of hire 2/9/11: A tuberculosis screen and chest X-ray was found for the date of hire on 2/11/11. A current annual screen, due in February, 2012, was not found. F. Social Service #4, with a re-hire date of 6/20/11: The annual P.P.D. was completed late on 7/16/12. G. Activity Assistant #18, with a hire date of 6/29/11: The annual P.P.D. was completed late on 7/9/12. In an interview during the daily conference on 8/22/12 at 4:15 P.M., the Director of Nursing indicated she had identified a problem with tuberculosis testing for both residents and employees in May, 2012 through the facility's Quality Assurance program. She had initiated an action plan during that month,		New hires are administered the 1 st Step PPD, prior to hire, and annually. Employee annual PPDs have been scheduled, as needed. The Staff Development has created a calendar to track employee second step and annual PPD due dates. The Staff Development Coordinator is responsible for compliance with employee PPDs. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Personnel File audit tool will be utilized for new hires monthly to review 1 st and 2 nd step PPDs. Employee's annual PPDs will be administered on the same month each year and audited q 6 months. The audits will be reviewed by the CQI committee and should a threshold of 95%	

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	and those employees and residents who did not have initial, or current, skin tests or screens were re-tested. 3.1-14(t)(1)		compliance not be met action plans will be developed to ensure ongoing compliance.	
R0000	These State Residential findings are cited in accordance with 410 IAC 16.2-5	R0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and request a **desk review** on or after September 23, 2012.	

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R0092	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure that it attempted to hold fire drills in conjunction with the local fire department at least every 6 months. Findings include: On 8/20/12, at entrance conference at 10:00 A.M., the Executive Director (E.D.) and Director of Nursing (DON) were asked to provide documentation of	R0092	R 092 1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Administrator met with local Fire Marshall and Captain on September 7, 2012 to discuss the need for conducting joint fire drills and staff education. Fire Marshall indicated that he would like to review facility's fire plan and then would contact the Administrator to schedule the first joint fire drill. 2) **How the facility will identify other residents**	09/21/2012

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	completed fire drills for the previous one year period. On 8/24/12 at 11:30 A.M., the documentation of fire drills was reviewed. There was no indication that the local fire department had participated in any of the completed fire drills reviewed. The E.D. and DON were asked to provide any additional documentation they had regarding fire drills done in coordination with the local fire department. In an interview on 8/24/12, at 12:00 P.M., the E.D. and DON were asked if they had any additional documentation regarding coordination of fire drills with the local fire department. They indicated they had not been aware they were required to coordinate fire drills with the local fire department. No additional documentation was provided.		**having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. Fire drills will be held quarterly on all three shifts and a minimum of twice per year in conjunction with the Fire Department 3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Joint fire drills and staff education will be set on a routine schedule and will be documented in the maintenance monthly fire drill schedule book that is kept in the maintenance office. 4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** The maintenance Director will be responsible to ensure that the local fire department are called and scheduled to be at the facility at the time of the fire drill. Facility Administrator or designee will review all fire drill documentation quarterly to ensure proper drills and education was conducted.	

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R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure that potentially hazardous chemicals and sharp items were not accessible to residents. This deficient practice had the potential to affect 21 of 21 residents who resided on the "Cottage 1" unit (a locked/secured Alzheimer's/dementia unit) who ambulated independently. Findings include: On 8/23/12, at 10:30 A.M., the tour of the general environment of the residential/assisted living section of the facility was initiated with the Assistant	R0148	R 148 1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All identified hazards were immediately removed and secured . 2) **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents on cottage 1 have the potential to be affected. Nursing staff will monitor resident areas to ensure all hazardous materials and sharps are	09/21/2012

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	Executive Director, the Maintenance Supervisor, the Laundry/Housekeeping Supervisor, and the Memory Care Facilitator in attendance. On 8/23/12, at 10:50 A.M., a bathroom in the hallway next to the nurse's station was found to be unlocked and to contain a plastic container labeled "Sani-Cloth Germicidal Disposable Wipe." The label indicated, "Hazard to human and domestic animals. . ." "Caution: causes moderate eye irritation. Harmful if absorbed through skin. Avoid contact with eyes, skin, or clothing. . ." "First aid: If in eyes: hold eye open and rinse slowly. If on skin or clothing, take off contaminated clothing. Rinse skin immediately with plenty of water for 15-20 minutes. Call a poison control center or doctor for treatment advice." Also found in this same bathroom was a 300 ml bottle of "Array perineal wash" with a label that indicated, "Keep out of reach of children. For external use only." Also found in this same bathroom were two 8.5 ounce bottles of "McKesson Wash for Hair and Body." The labels of each bottle indicated this product was for "External use only. Discontinue if irritation occurs. Avoid contact with eyes. In case of eye contact flush with		properly secured. All staff have been re-educated on proper storage of chemicals and other hazardous materials by the Staff Development Coordinator and Memory Care Coordinator on August 28 th . 3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Maintenance Director and Assistant Administrator shall make rounds daily to ensure that all hazardous materials are stored behind a locked door or cabinet. All locks will be checked to ensure proper functionality. All findings will be corrected immediately 4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** The Care Rep Daily rounds Checklist will be utilized on the unit daily x 30 days, monthly x 2 and quarterly x 3. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met, action plans will be developed to ensure ongoing compliance.	

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	water and contact a physician." One bottle was observed to be full, and one was observed to be 1/2 full. Also found in this same bathroom was an 11 ounce can of "McKesson Medi-Pak shaving cream" with a label indicating, "Contents under pressure. Keep out of reach of children." On 8/23/12 at 11:10 A.M., the Cottage 1 dining room/activity area was observed. In the center of this area was a kitchenette with a sink enclosed in one row of cabinets extending outward at a right angle from the wall, and another row of cabinets facing the sink and this first row of cabinets. On the right side, across from the sink, a drawer was found to contain a pair of metal scissors with a rounded end. On this same row of cabinets, another drawer was found to contain a plier-shaped metal "toenail clipper" with a sharp cutting edge. Next to the sink were observed three drawers. The bottom drawer was observed to contain a metal, folding nail clipper with a pointed file that could be rotated to extend out to the side of the clipper.			

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	In an interview at the time of the Cottage 1 dining room observation, the Memory Care Facilitator indicated he would secure the items.			

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R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to obtain a signature from the resident on the agreed upon service plan. The deficient practice affected 4 of 7 residents reviewed. [Residents #10, 69, 50, and 201]. Findings include:	R0217	R217 1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents' #10, #69, and #50 service plans have been updated and signatures of responsible parties obtained. Resident #201 no longer resides at the facility 2)	09/21/2012

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	1. On 8/23/12 at 2:05 P.M., Resident #10's record was reviewed. Diagnoses included, but were not limited to, progressive dementia, agitation, and history of alcohol dependence and abuse. A "Service Plan for Residential Care," dated 1/19/12, did not have a resident signature. A "Service Plan for Residential Care," dated 7/26/12, did not have a resident signature. 2. On 8/24/12 at 10:10 A.M., Resident #69's record was reviewed. Diagnoses included, but were not limited to, inflammatory bowel disease and gastritis. A "Service Plan for Residential Care," dated 9/7/11, was signed by the resident; however, the semi-annual service plan, dated 3/21/12, was not signed by the resident. 3. On 8/24/12 at 10:28 A.M., Resident #50's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. A "Service Plan for Residential Care," dated 3/16/12, was not signed by the resident.		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of all current residents' service plans was conducted. All residents with current service plans found to not have a signature from either the resident or the responsible party have been contacted and asked to sign the service plan. 3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Facility representative will complete service plans with alert and oriented resident in a face to face meeting. If resident is not alert and oriented or refuses to assist in completion of their service plan, a phone call will be placed to resident's responsible party offering a time to come into facility to discuss the new service plan. If residents responsible party refuses to meet or is unable to come to the facility to discuss service plan, a copy will be mailed to them with a self addressed stamped envelope so that they can review, sign, and return to facility. Resident service plans completed during the previous week, including new admissions, semi annual assessments, and residents with a change of condition, will be reviewed during the weekly at- risk meeting to	

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	4. On 8/24/12 at 10:55 A.M., Resident #201's closed clinical record was reviewed. Diagnoses included, but were not limited to, dementia with agitation. A "Service Plan for Residential Care," dated 1/19/12, was not signed by the resident's legal representative. 5. In an interview on 8/24/12 at 11:15 A.M., LPN #5 indicated she was aware all agreed upon service plans required either the resident's signature or the resident's legal representative.		assure that the proper signatures have been obtained. 4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** Service plans will be monitored and audits completed monthly by Assistant Administrator, in addition to the weekly reviews during at-risk meetings. Audits will be reviewed monthly by the CQI committee and should a threshold of 95% compliance not be met, action plans will be developed to ensure ongoing compliance.	

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R0304	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to ensure 1 of 2 medication carts were not left unlocked or unsupervised. This deficient practice had the potential to affect 64 of 85 residents residing on the non-locked/secured residential care unit. Findings include: On 8/21/12 at 11:30 A.M., medication pass was observed with Licensed Practical Nurse [LPN] #2. At 11:45 A.M., LPN #2 left a medication cart unattended, unlocked, and with her facility keys laying on top of the cart, in the hall dividing resident rooms. In addition, two elevators were located near the unattended medication cart. From 11:45 A.M. to 12:00 P.M., LPN #2 remained out of sight of the unlocked medication cart. Residents were observed passing the cart on their way to lunch.	R0304	R304 1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** LPN #2 was re-educated on locking the medication cart at all times and not meeting these standards of practice. The medication cart was secured immediately and there were no negative resident outcomes. 2) **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. Employees were in-serviced on August 28, 2012, and ongoing by the Staff Development Coordinator, or designee, on standards of practice, i.e., insuring all medication or treatment cabinets, carts, or med rooms will be locked at all times unless attended to by an associate with privileges allowing them to have access to those areas.	09/21/2012

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	At 12:00 P.M., in an interview, LPN #2 indicated she didn't realize the cart was left unlocked with her facility keys left unattended. At that time, LPN #2 locked the cart and removed the keys.		Department supervisors monitor medication carts/rooms daily to ensure they are secured. 3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Clinical Director or designee will audit med carts and med rooms to ensure that they are being kept locked at all times when a clinical staff is not present. 4) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place** Audits will be conducted daily X 4 weeks, weekly X 2 months, and quarterly X3. Findings from these audits will be reviewed at monthly CQI meeting and should a threshold of 95% compliance not be met corrective action plans will be implemented to ensure ongoing complianc	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0408	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on observation and interview, the facility failed to obtain a resident's chest x-ray prior to admission to the facility. This deficient practice affected 1 of 7 residents reviewed for admission chest x-rays. [Resident #69] Findings included: On 8/24/12 at 10:10 A.M., Resident #69's record was reviewed. Diagnoses included, but were not limited to, inflammatory bowel disease and gastritis. Resident #69 was admitted to the facility on 9/15/11. A "Resident Immunization and Health History Form" included, but was not limited to , "Chest x-ray: [completed on] 9/22/11. On 8/24/12 at 11:15 A.M., LPN #5 indicated she was aware residents must have a chest x-ray prior to admission to the facility. On 8/24/12 at 5:00 P.M., the Director of Nursing was unable to provide documentation of an admission chest	R0408	R408 1) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**. Resident # 69 admission chest x-ray was located and present on medical record. 2) **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The facility conducted an audit and any residents needing a chest x-ray were identified and chest x-rays have been obtained. 3) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Leasing Director has been in-serviced on the policy to have a documented chest x-ray on all new residents. Clinical Director or designee will review all admission paperwork prior to admission to ensure a chest x-ray has been obtained. 4) **How the corrective action(s) will be monitored to ensure the**	09/21/2012

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	x-ray for Resident #69.		**deficient practice will not recur, i.e. what quality assurance program will be put into place.** Assistant Administrator will audit all new AL admission paperwork weekly to ensure chest x-rays were obtained prior to admission. Findings from these audits will be reviewed at monthly CQI meeting and should a threshold of 95% compliance not be met, corrective action plans will be implemented to ensure ongoing compliance.	

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R0410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to perform tuberculin skin testing as required to residents on admission or annually. This deficient practice affected 2 of 7 residents reviewed for required tuberculin skin testing. [Residents #10 and #69] Findings include: 1. On 8/23/12 at 2:05 P.M., Resident #10's record was reviewed. Diagnoses included, but were not limited to, progressive dementia and a history of alcohol use and abuse.	R0410	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents # 69, # 10 – The resident's 1 st and 2 nd step tuberculin testing has been initiated and will be completed timely. . **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Residents have a 2-step testing for tuberculosis (TB) and may be	09/21/2012

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	A "Resident Immunization and Health History Form" included, but was not limited to, "Mantoux Tests [tuberculin skin testing]: 8/16/10 and 4/18/12 [both results as 0 millimeters or negative]. There was no documentation of tuberculin skin testing in 2011. 2. On 8/24/12 at 10:10 A.M., Resident #69's record was reviewed. Diagnoses included, but were not limited to, inflammatory bowel disease and gastritis. Resident #69 was admitted on 9/15/11. A "Resident Immunization and Health History Form" included, but was not limited to, "Mantoux tests: 9/30/11.... read on 10/2/11 with millimeter results [negative]..." There was no documentation of an admission tuberculin skin test. On 8/24/12 at 12:00 P.M., in an interview, the Director of Nursing indicated she did not have any other documentation for the tuberculin skin testing for Residents #10 and #69. She indicated that a problem with tuberculin skin testing was identified by the facility in May 2012.		completed within 3 months prior to admission and upon admission to the facility. The facility conducted an audit and any residents needing tuberculin testing were identified and PPDs have been placed and/or are in the process of continuing the series. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Licensed nurses were re-educated on the scheduling and administration of resident PPDs on August 28, 2012 by the Staff Development Coordinator. The facility conducted a TB Testing Certification Class on August 31, 2012, and September 14, 2012, and will continue to have opportunities for Licensed Nurses to become and/or remain PPD certified. Residents are assessed upon admission for PPDs. The 1 st Step PPD is given on date of admission, if not given prior to admission and the charge nurse schedules the necessary steps to complete the series. Annual PPDs have been scheduled, as needed. Nurse managers review the resident's hospital information on the day of admission to determine the date of the resident's 1 st Step PPD and schedules the series, as necessary. Nurse managers review the resident's medical record the day after the admission to the facility to ensure	

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			the 1 st Step PPD has been administered and scheduled to be read and the 2 nd Step series is scheduled. The Director of Nursing Services or designee will also run a report from the Electronic Medical Record monthly that will indicated any resident who does not have a current PPD documented. The Director of Nursing Services is responsible to ensure compliance with resident PPD administration. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Resident Mantoux CQI tool will be utilized daily x 30 days on new admissions, weekly x 4, monthly x 2, and quarterly. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met, action plans will be developed to ensure ongoing compliance.	